



Application for Certification as a Long Term Care Agency, Non-Agency and Assisted Living Service Provider

I. IDENTIFYING INFORMATION

1. Legal Name of Applicant:		
2. Doing Business As (dba), if applicable:		
3. Social Security # (individuals)		4. Federal Tax ID # (partnerships & corporations):
	5. Business Address (may not use a post office box)	6. Mailing/Billing Address: (if different) (may not use a post office box)
To Attention of:		
Street:		
City, State, & Zip:		
Phone #:	()	()
Toll-Free #:	()	()
FAX #:	()	()
Email:		
7. Have you ever had an Ohio Medicaid Provider Number? Yes <input type="radio"/> No <input type="radio"/> Provider No.:		8. Are you a Medicare Certified Home Health Agency? Yes <input type="radio"/> No <input type="radio"/> Provider Number:
9. Ownership (check appropriate category): <input type="radio"/> Private <input type="radio"/> Private/Non-profit <input type="radio"/> Public/Government <input type="radio"/> Charitable/Religious <input type="radio"/> Other (describe):		
10. Legal Structure (check appropriate category): <input type="radio"/> Sole Proprietorship <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> S Corporation <input type="radio"/> Non-Profit Corporation <input type="radio"/> Limited Liability		

II. KEY PERSONNEL

11. Full name and address of C.E.O.*
12. Full name and address of agency administrator (if different from C.E.O.)*

* In the event ODA can not determine whether one or more individuals are eligible to be certified as a long-term care provider, ODA may require the social security number(s) of those individuals. Failure to cooperate with this requirement will lead to sanctions against the provider.

13. Name, Title, and Phone # for Service Orders:
14. Name, title, address and phone of individual authorized to sign application.
15. How will you be submitting your bills: <input type="radio"/> Paper <input type="radio"/> CD Rom <input type="radio"/> Direct Data Entry <input type="radio"/> EDI <input type="radio"/> Other: _____
16. Type of certification: <input type="radio"/> COA <input type="radio"/> JCAHCO <input type="radio"/> CARF <input type="radio"/> CHAP <input type="radio"/> RCF License #: _____
17. Has there been a change in ownership, control, administrator, director of nursing or other key individuals in the last year? Yes <input type="radio"/> No <input type="radio"/> If yes, attach explanation, including dates.
18. Do you anticipate any change in ownership, control, administrator, director of nursing or other key individuals within the year? Yes <input type="radio"/> No <input type="radio"/> If yes, attach explanation, including dates.
19. Are there any Directors, Officers, Agents, Owners, or Managers who have ever been convicted of a felony under State or Federal Law? Yes <input type="radio"/> No <input type="radio"/> If yes, attach explanation including names, dates and type(s) of offense
20. Is the applicant operated by a management company or fiscal representative? Yes <input type="radio"/> No <input type="radio"/> If yes, attach explanation
21. Date the applicant was officially established in the State of Ohio:
22. Date the applicant began providing services for consumers:
23. Does your agency have an employee drug testing policy and procedure? Yes <input type="radio"/> No <input type="radio"/>

Applications for all providers must include the following items as attachments to the application:

- A. Statement of ownership: for non-government owned applicants, provide full name and address of each person and/or entity with 5% or more ownership*
- B. Governing Body: for non-government owned applicants, provide full name and address of each member of the governing body%
- C. Completed, signed W-9 form
- D. Completed, signed DMA form for all owners of the provider agency or non-agency

Applications for Agency providers must include attachments A-D and the following:

- E. Copy of registration with Ohio Secretary of State
- F. Copy of current certificate of insurance with Ohio Bureau of Workers Compensation
- G. Copy of current certificate of liability insurance and coverage of consumer loss due to theft or property damage
- H. Copy of a table of organization that includes the full name of each position and indicates lines of authority

Applications for Assisted Living providers must include attachments A-D and the following:

- I. Copy of Residential Care Facility (RCF) license
- J. Copy of pages 1-2 of LTC Consumer Guide information packet
- K. Facility floor plan indicating the location of the units and a list of the units to be certified for the ALW program
- L. Table of organization for the facility
- M. Copy of the provider's resident agreement
- N. Copy of current certificate of insurance with Ohio Bureau of Workers Compensation
- O. Copy of current certificate of liability insurance and coverage of consumer loss due to theft or property damage

* In the event ODA can not determine whether one or more individuals are eligible to be certified as a long-term care provider, ODA may require the social security number(s) of those individuals. Failure to cooperate with this requirement will lead to sanctions against the provider.

ASSURANCES

These assurances are made by the undersigned provider to the Ohio Department of Aging. The Provider agrees to comply with these assurances, state statutes, Ohio Administrative Code rules and Federal statutes and rules, and agrees and certifies to:

1. Provide services as authorized by the case manager without regard to race, creed, color, age, sex, sexual orientation, national origin, source(s) of payment, handicap or disability.
2. Submit claims only for services actually provided and bill ODA for no more than the usual and customary fee charged other patients for the same service.
3. Ascertain and recoup all third-party resource(s) available to the consumer prior to billing ODA.
4. Accept the allowable reimbursement for all covered services as payment-in-full and will not seek reimbursement for that service from the consumer, any member of the family, or any other person.
5. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions for a period of three years after the date of receipt of the payment based upon those records or until an audit is initiated within the three year period, until the audit is completed and every exception resolved, whichever is longer.
6. Furnish to ODA and/or its designee any information maintained under paragraph 5 above for audit or review purposes. Failure to supply requested records within thirty days may result in revocation of certification as a long term care service provider.
7. Inform ODA within thirty days of any changes in licensure, certification, ownership, control, operational management, address, business name, telephone number and/or federal tax identification number.
8. Immediately notify ODA in writing of any owner, director, officer, or operational manager who is subject to sanction under Medicare, Medicaid, or any Title XX program or service.
9. Immediately notify ODA in writing of any owner, director, officer or operational manager, employee or contractor who has been convicted of a criminal offense as outlined in 173.41 of the Revised Code.
10. Comply with the Conditions of Participation set forth in section 173-39-02 of the Administrative Code and the service specifications set forth in sections 173-39-02.1 through 173-39-02.18 of the Administrative Code.
11. Provide to ODA, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to Provider Certification, Ohio Department of Aging, 50 West Broad Street, Columbus, Ohio 43215.
12. Ensure no owner, officer, authorized agent, associate, manager or employee has been determined ineligible to be associated with a Medicaid program.
13. The authorized representative signing these assurances certifies that the information contained in these assurances and in the application for certification as a long term service provider is complete and true.

Signature	Title
Printed name	Date

Services You Seek Certification to Provide	PASSPORT Program	Choices Program	Assisted Living	Counties You Propose to Serve (N/A for Assisted Living)	Proposed Rate
<input type="checkbox"/> Adult Day Services: Enhanced					
<input type="checkbox"/> Adult Day Services: Intensive					
<input type="checkbox"/> Adult Day Services: Transportation <input type="checkbox"/> per mile <input type="checkbox"/> per trip <input type="checkbox"/> per roundtrip					
<input type="checkbox"/> Chore Service: _____					
<input type="checkbox"/> Emergency Response System <input type="checkbox"/> Monthly Rental <input type="checkbox"/> Installation					
<input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Therapeutic Diet					
<input type="checkbox"/> Homemaker					
<input type="checkbox"/> Independent Living Assistance <input type="checkbox"/> Telephone Support <input type="checkbox"/> In-Person Activities <input type="checkbox"/> Travel Attendant					
<input type="checkbox"/> Nutrition Consultation					
<input type="checkbox"/> Personal Care					
<input type="checkbox"/> Social Work/Counseling					
<input type="checkbox"/> Home Medical Equip./Supplies <input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Nutritional Supplements <input type="checkbox"/> Hygiene & Disposable <input type="checkbox"/> Repairs					
<input type="checkbox"/> Minor Home Modifications					
<input type="checkbox"/> Medical Transportation					
<input type="checkbox"/> Non-Medical Transportation					
<input type="checkbox"/> Nursing Service					
<input type="checkbox"/> Physical Therapy					
<input type="checkbox"/> Occupational Therapy					
<input type="checkbox"/> Speech Therapy					
<input type="checkbox"/> Assisted Living Service					
<input type="checkbox"/> Community Transition Service					
<input type="checkbox"/> Choices Alternative Meal Service					
<input type="checkbox"/> Choices Home Care Attendant Service					
<input type="checkbox"/> Choices Pest Control					

MEDICAID WAIVER PROVIDER ENROLLMENT

I am requesting enrollment as a Medicaid Provider for the following Home and Community-Based Services Waiver: PASSPORT Choices Assisted Living

I currently provide services for the following Waivers (if applicable):
 AIDS Assisted Living PASSPORT Choices Disability Medically Fragile OBRA Individual Options

Provider Name: Phone #: ()	Pay to address: Street: City, State, Zip:																																	
Federal Tax ID # or Social Security #:	Medicaid Provider Number, if applicable: <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td> </tr> </table>																	Medicare Number, if applicable: <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td> </tr> </table>																
Signature:	Title:																																	
Printed Name:	Date:																																	

TO BE COMPLETED BY STATE AGENCY:

° Add category of service to current Medicaid number.

° Assign a new provider number and category of service. Attached is completed and signed Medicaid Provider Agreement.

The State Agency has certified this provider for the following waiver services in these counties at the following rates and recommends approval for enrollment:

SERVICES	PRIMARY COUNTIES TO BE SERVED	RATES
		\$
		\$
		\$
		\$
		\$

State agency approval signature: ODA MRDD BCS

Printed name:	Eff. Date
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ODHS Provider Enrollment Signature: Date:

Medicaid Provider Number Assigned:	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td><td style="width:5%;"></td> </tr> </table>															